Rhode Island Department of Mental Health, Retardation and Hospitals
Office of Facilities and Program Standards and Licensure
14 Harrington Road, Cranston, Rhode Island 02920
Phone: 462-6049 Fax: 462-0393

APPLICATION FOR LICENSURE RENEWAL
OR
TO ADD A SERVICE OR ADD A SITE
TO PROVIDE BEHAVIORAL HEALTHCARE SERVICES

DATE: _____

License #:_____

APPLICATION FOR: Renewal of License: _____ **Add a Service:** _____ **Add a Site:** _____

Applicant Information: Identify the person, partnership, corporation, association, or governmental agency applying to lawfully establish, conduct, and provide services:

Name of Organization: _____

Mailing Address: _____

City:_____ State:_____ Zip Code: _____

Telephone:_____ Fax:_____ FEIN: _____

Chief Executive Officer or Director: Identify the person responsible for the overall management and oversight of the service(s) to be operated by the applicant:

Name:_____ Title: _____

Telephone:_____ Fax:_____ Email Address: _____

Name of Facility/Program (If adding a site or service):_____

Address: _____

Name of Contact Person:_____ Title: _____

Telephone Number:_____Fax Number:_____License Number:_____

Proposed Opening Date (if New): _____

Service Type: _____

Name and Address of Owner:_____

_____

Type of Building(s): Apartment___ Condominium___ Single Family___ Duplex___ Multi-Family ___

Type of structure:_____Wood frame _____ Masonry _____ Metal _____

Number of Stories:____ Number of Rooms:_____Type of Zoning:_____

Does building have a fire sprinkler system? Yes: _____ No: ____

Is building fire alarm connected to local fire department? Yes: _____ No: _____

Date and Results of last State Fire Marshal Survey: _____

If rented or leased, is owner willing to allow any necessary repairs or renovations to be made to the building to meet necessary life-safety requirements? Yes: _____ No: _____

If No, what is your alternative plan? _____

Does building comply with all applicable federal, state and local laws, codes, rules and regulations relative to health, accessibility, fire safety, building, minimal housing and zoning? Yes___ No ___

Is facility or program licensed, certified or accredited by any other authority? Yes_____ No _____

If yes, by what authority and list types of license, accreditation or certification?

Do you wish to be granted deemed status for the annually designated standards? Yes_____ No _____

If yes, please attach a copy of the most recent accreditation report.

If no, and your organization is accredited, please attach an explanation specifying the reason(s).

Has any application for a license, certification or accreditation ever been refused? Yes____No _____

If so, explain: _____

Selected Services Information: Use the list below to identify the service type(s). If the service type(s) is not listed, please note in the service information section**:**

1. General Outpatient Services
2. Integrated Dual Diagnosis Treatment
3. Medication Services
4. Laboratory Services
5. Case Management Services
6. Community Psychiatric Supportive Treatment
7. Intensive Outpatient Services
8. Community Integration Services
9. Supported Housing Services
10. Residential Services
11. Outpatient Detoxification Services
12. Medical Detoxification Services
13. Opioid Treatment Programs

NARRATIVE

Please describe any changes in any elements of authorized services since the last application was submitted.

Please describe any changes of the organization's owners and/or officers, and any changes in the organizational structure since the last application was submitted.

FINANCIAL

If a new service, describe the proposed financial plan.

If a renewal, list accountant and date of last audit.

Additional required information:

Attach an updated copy of the organization's Board of Directors (for renewal only).

In applying for deemed status I understand and acknowledge that sections of the *Rules and Regulations for the Licensing of Behavioral Healthcare Organizations* are deemed solely at the discretion of the Department. I agree and acknowledge that denials or revocations of all or part of deemed status by the Department are neither subject to appeal nor review.

I am aware that authorized representatives of the Licensing Agency have the right to enter without prior notice to inspect the entire premises and services, including all records of any facility for which an application has been received or for which a license has been issued. This application shall constitute permission for and willingness to comply with such inspections.

I am aware of the statutory authority of the Department as contained in chapter 40.1 of the Rhode Island General Laws, and of the standards, rules and regulations prescribed thereunder, which regulate the operation of behavioral healthcare treatment facilities and programs.

TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL INFORMATION CONTAINED HEREIN IS CORRECT AND COMPLETE. I FURTHER DECLARE MY AUTHORITY AND RESPONSIBILITY TO MAKE THIS APPLICATION.

Signature of Applicant:_____ Date: _____

Title: _____

If you have any questions concerning the application, please contact this office at (401) 462-6049.
This application is to be returned within 30 days to:

IAN KNOWLES, ADMINISTRATOR OF COMMUNITY SERVICES
OFFICE OF FACILITIES AND PROGRAM STANDARDS AND LICENSURE
DEPARTMENT OF MENTAL HEALTH, RETARDATION AND HOSPITALS
ROOM 203, BARRY HALL
14 HARRINGTON ROAD
CRANSTON, RHODE ISLAND 02920